

Division of Health Care Facilities

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments Investigation of complaint #30244 was conducted September 5, 2012. No deficiencies were cited under 1200-8-6 Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

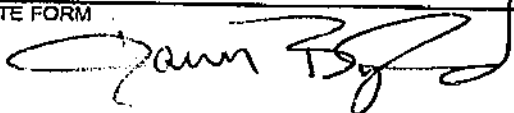
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If continuation sheet 1 of 1



OCT 09 2012